

CHILD PROTECTION SERVICES  
STANDARDS FOR EFFECTIVE PRACTICE

**STANDARDS FOR ADMINISTRATION**

**10.14 MANAGING SYSTEMS OF CARE**

**Council on Accreditation Standards**

There are no Council on Accreditation Standards that directly link to and support Standard 10.14 *Managing Systems of Care*.

**Administrative Code**

The Ohio Administrative Procedures Manual, Chapter 4000, Section 4424; 4425 and 4460 address Standard 10.14 *Managing Systems of Care*.

**I. Philosophy**

Public CFSAs promote, through their mission statement, the physical safety and social, emotional, and developmental well-being of children and their families. In an effort to manage systems of care, staff use clinical and administrative tools to enhance their ability to efficiently and cost effectively serve children and their families. This process of managing systems of care is often referred to as "managed care."

Managed care, as a strategy, is based on multiple activities centered on providing expedient, quality services. Critical and basic principles of managed care include:

- a. collection, analysis, reporting of utilization, outcomes and cost data;
- b. quality assurance mechanisms and data-based operations;
- c. standardized gatekeeping and service protocols\*;
- d. outcome-based, results-oriented services;
- e. cost containment.

Public CFSAs may choose to:

- a. apply managed care principles to their internal administrative practices;
- b. contract with providers to serve children and families within a managed care environment; or
- c. operate using a combination of strategies, all aimed at providing the very best service delivery system to children and families.

Regardless of the option selected, managed care provides agencies with an opportunity to assure results while containing costs, creating a balance between high quality services and available resources.

*\*Protocols should serve as a foundation to build on, but should not inhibit innovation of the service delivery system.*

**II. Outcome**

Continuous quality improvement occurs and costs are contained.

### III. Evaluation

FACSIS events, CPOE and the Federal Health and Human Services outcomes may be considered when evaluating this standard. In addition, the CFSA may consider the following:

- surveying contractual Providers;
- reviewing data gathered to review the Managed Care QA plan and report out on findings;
- meeting with Providers to share data and identify solutions for future contracting.

### IV. Standards for Implementation

#### A. Options

- 1) In moving into a managed care system for the delivery of services to children and families, the Public CFSA has the option of selecting from a continuum of alternatives to provide and monitor service to children and families. It should be entirely up to the Public CFSA to determine the most appropriate managed care environment based on its values and desired outcomes, community needs, level of inter-system collaboration, and finances.

#### B. Public CFSA Applied Managed Care Principles Internally

- 1) The Public CFSA may choose to provide all child protective services and apply managed care principles to its own administrative and direct service programs. Applying managed care principles within the organization, the

Public CFSA would evaluate its systems, services, costs, effectiveness, and operations with a specific focus on direct service programs.

In an effort to continuously improve and contain costs, the Public CFSA:

- a. subcontracts for selected services and acts as the manager for services provided including, but not limited to, providing administrative, fiscal, quality assurance and case management responsibilities;
- b. maintains direct service responsibilities for specific services (e.g., Intake investigations and assessments);
- c. has the administrative organizational capacity to support a comprehensive and quality managed care program, and the qualifications to handle a variety of operations including, but not limited to:
  - i. utilization management and service authorization;
  - ii. quality assurance system including a medical and clinical review system;
  - iii. investigation of member and provider complaints and grievances system;
  - iv. fiscal management system;
  - v. evaluation and monitoring of programs, fiscal activities, contracts, providers, outcomes and service data;
  - vi. client tracking and care coordination.

#### C. The Managed Care Entity

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- 1) A Public CFSA may elect to contract with a managed care entity (MCE) for all (or some) agency services to children and families. The Public CFSA would:
    - a. maintain responsibility for executive decision-making, quality assurance, and Management Information Services, maintaining policies on clients to be served, and establishing the outcomes for program services;
    - b. maintain legal responsibility for all activities but not necessarily perform any of them;
    - c. have the administrative organizational capacity to handle a variety of office functions, including:
      - i. development and implementation of service protocols and standardized approaches to gatekeeping decisions and safety and permanency decisions;
      - ii. oversight of the data collection system;
      - iii. development and oversight of provider credentialing standards and processes;
      - iv. development and review of outcomes and standards;
      - v. collection, evaluation, monitoring program and fiscal data, providers, outcomes and service data;
      - vi. client tracking and care coordination;
      - vii. review of safety and permanency decisions.
    - d. address the parameters of the contract between the parties (see Standard 10.10 *Contract Development*).

#### **D. Gatekeeper**

The Public CFSA is obligated by law to protect children who are alleged to be abused or neglected. The Public CFSA should maintain primary responsibility and authority for gatekeeping activities and decision-making, including intake and assessment, safety and permanency services.

- 1) The Public CFSA should develop a system for case reviews to determine which children will be eligible for which managed care services. The system can include Team Decision Making (case staffings, Family Case Conferences) with the family, provider, Public CFSA, other identified stakeholders, etc., and have protocols in cases where the Public CFSA and provider disagree on approval of the service requests (e.g., request a clinical review).
- 2) The Public CFSA should create advanced written Contracts with stakeholders to define how the Public CFSA, managed care entity, family, and other key stakeholders will work together, exchange information, etc.

#### **E. Management Information Systems & Managed Care**

- 1) Managing information is essential when managing systems of care. Both small and large county agencies should have the capacity to collect, store, analyze, manipulate, apply, and report data on clients, providers, finances, service effectiveness and state and federal compliance requirements whether manually or through an automated system. Management information systems should permit appropriate agency staff to access aggregated information and costs. Protecting confidentiality and ensuring the system's security is an additional component of a well-functioning data collection system equally critical to effectively managing system's of care.

## F. Functional Requirements

The data collection system must be able to manage certain functions. If these functions are not an integral part of the data system, the Public CFSA will place itself at risk of being unable to manage the system of care

effectively. The ability to track costs to services, monitor service delivery on a daily basis, and forecast service needs and costs is critical to the Public CFSA's effectiveness in a managed care environment.

- 1) The Public CFSA may choose to allow the MCE to perform all or some of the electronic data gathering. In this case, the Public CFSA must assure that its electronic system is compatible with the MCE's system to allow for the sharing, retrieval and storage of information.

The following data elements may be considered when establishing a managed care data gathering system:

- a. daily tracking and reporting of treatment services;
- b. client progress against stated outcomes;
- c. centralize, standardize and simplify record keeping with regards to:
  - i. essential client data,
  - ii. treatment plans and records,
  - iii. tracking costs on a daily basis, link costs to services, claims payments,
  - iv. provider data,
  - v. intake forms and eligibility criteria,
  - vi. outcome measures;
- d. system for accurate adjudication of approved and denied claims (if the Public CFSA is the managed care entity rather than a provider of services);
- e. useable data for forecasting:
  - i. budgets,
  - ii. staffing needs for services operated by agency,
  - iii. need for contract services,
  - iv. services needed by clients (both those currently provided and alternatives which may be less restrictive and more cost effective),
  - v. case-by-case future period cost estimates based on treatment plan to determine costs outside of the normal range,
  - vi. productivity of staff and providers for use in forecasting service needs and cost effectiveness;
- f. system for making information available to all staff, while protecting confidentiality and maintaining data security and addressing HIPPA standards;
- g. flexible reporting capacity that allows queries by staff, as well as preparation of ongoing reports for external and internal needs;
- h. provide Decision-Making Tools:
  - i. decision-making tools for standardizing the range/level of care to be authorized,
  - ii. system for reporting costs by service type, client and outcomes,
  - iii. forecasting tools, such as specialized reports on changing client demographics and specific treatment needs, service utilization by

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- provider type and client behaviors that have an adverse affect on positive treatment outcomes,
  - iv. quality assurance/analytical reports,
  - v. research capabilities;
  - i. Facilitate Tracking:
    - i. authorization of services,
    - ii. service provider file, including list of services authorized and the licensing or credentialing status of each individual provider,
    - iii. list of benefits (covered services), rates or fee schedule,
    - iv. tickler system to trigger periodic reviews of reports and plans (treatment plans, SARs, quality assurance, financial reports, etc.).

### **G. Quality Assurance**

- 1) A Quality Assurance system is comprised of a set of comprehensive reviews and monitoring activities designed to assess and evaluate the quality, effectiveness, efficiency and appropriateness of the Public CFSA's services and service delivery system. All quality assurance systems begin with the development of a comprehensive quality assurance plan.

### **H. Quality Assurance Plan**

The Public CFSA operating and/or participating in a managed care system should have a written quality assurance (QA) plan that identifies the agency's goals, objectives, and responsibilities for monitoring services.

The QA plan should be comprehensive, integrated into agency operations, and designed to assess the attainment of specific agency and individual client goals and objectives. The QA plan outlines well-defined activities through which data is collected and performance is measured.

- 1) The implemented QA plan is intended to:
  - a. identify system strengths and weaknesses;
  - b. monitor compliance as related to best practice;
  - c. identify gaps in the service delivery system and monitor use of community resources and systems.
- 2) The plan would include, but not be limited to, the following components:
  - a. case plan reviews;
  - b. utilization reviews;
  - c. compliance monitoring;
  - d. assessment of staff performance;
  - e. records review.
- 3) The quality assurance plan should include the following additional items:
  - a. statement of purpose, identifying broad-based quality assurance goals, and objectives;
  - b. identification of staff responsible for coordination of QA activities and for assuring compliance with program standards;
  - c. written policy regarding client confidentiality, including statement, which holds confidential all names and addresses;

- d. statement regarding necessity to avoid conflict of interest in reviewing one's own work;
- e. identification and definition of scope of services against which measurements will be made;
- f. reporting requirements and methods for follow-up, corrective action and strategies for improvement, including a mechanism for continuous quality improvement;
- g. method for receiving and providing staff feedback and for disseminating information and reports.

### **I. Utilization Review**

Public CFSAs currently use the Semi-Annual Review (SARs) and Administrative Case Review (ACRs) to review the effectiveness of services with specific clients. Public CFSAs can move beyond the SAR and ACR concept, by conducting or purchasing utilization review activities.

- 1) Monthly utilization reviews should rely on a review checklist to assure uniformity and consistency in the review process. The checklist may include, but not be limited to, a review of:
  - a. new admissions;
  - b. length of stay and discharge criteria;
  - c. trends and patterns of service usage;
  - d. involuntary terminations;
  - e. coordination of assessment, treatment and termination;
  - f. availability of services;
  - g. client waiting list;
  - h. referrals to other agencies including a survey of referral agencies;
  - i. continuity of services for clients;
  - j. clients progress on treatment plan;
  - k. client satisfaction surveys.
- 2) The utilization review process should include a designated Recorder for taking and maintaining a record of review minutes and outcomes.
- 3) The Public CFSA should hold regular reviews of randomly selected cases of current and recently terminated client's case records to determine if agency and community resources are being allocated appropriately to meet client needs. The selected sample should be representative of the total population.
- 4) On a regular basis, a qualitative and quantitative analysis and report should be prepared and presented to the Public CFSA administration for monitoring purposes and planning.

### **J. Peer Reviews**

The peer review process is based on a review of clinical performance by the clinician's peers. It addresses the clinical performance of each staff member in their ability to provide consistent, suitable and appropriate treatment and/or services.

- 1) When contracting with a provider to provide a specific service, the Public CFSA should assure, in the contract deliverables, the provision of a peer review process by the

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provider. In this case, the Public CFSA should participate in the peer review process on a quarterly basis (see standard 10.10 *Contract Development*).

- 2) The Public CFSA should review a sample of the case records of each clinician providing treatment and/or services at a minimum of once annually.
- 3) The Public CFSA may elect to create/require a peer review team to meet monthly. The review team should be comprised of direct care providers (e.g., social workers).
- 4) Cases for peer review should be pulled in advance and made available for the peer reviewers with a checklist for analysis. The peer review team meets monthly to review the case and determine to what extent the clinician provided appropriate treatment service.
- 5) On a monthly basis the Public CFSA should review a randomly selected set of client records. The peer reviewers should utilize a checklist to assure uniformity and consistency. The reviews should include, but not be limited to, the following:
  - a. an analysis of whether or not the clinician/provider provided the services and/or treatment as described in the Individual Service Plan (ISP) or case plan;
  - b. a clinical analysis as to whether or not the services were provided in a suitable manner;
  - c. a clinical analysis as to whether the services provided were appropriate based on the Individual Service Plan (ISP) or case plan;
  - d. a review as to whether or not the services were properly documented and completely documented.

#### **K. Quarterly Reviews**

The purpose of the Quarterly Review process is to review the client's progress towards stated outcomes, goals, and objectives. A review of the Individual Service Plan (ISP) should be approved by a qualified and licensed professional. Similar to the SAR, the quarterly review assists the agency and the client family to avoid case "drift." Whether the Public CFSA acts as the managed care entity (MCE), or contracts with a provider to provide MCE services, quarterly reviews should be expected and monitored.

- 1) The Public CFSA should require the use of a quarterly review checklist to assure uniformity and consistency. The checklist should be signed by a licensed professional.
- 2) The quarterly review checklist should address, but not be limited to:
  - a. necessity and plan for treatment;
  - b. appropriateness of treatment;
  - c. client progress;
  - d. appropriate duration of treatment;
  - e. adequacy of records and documentation;
  - f. clinical performance of staff;
  - g. utilization of agency and community resources;
  - h. conformity to protocols and standards.

#### **L. Records Review**

- 1) The records review process should assure compliance with all contracts and state requirements. The purpose of the records review process is to assure records are available and properly maintained and that the records documentation is pertinent, legible, timely and complete.

**M. Utilization Management**

Utilization management is a critical cornerstone in the development and operation of a managed care system. Regular reviews and analysis of provided services allow the agency to monitor service efficiency and effectiveness in an effort to maximize existing resources.

- 1) Utilization management should rely on a well developed Management Information System to allow for monitoring of provider service activities on a daily, weekly and/or monthly basis so that adjustments can be made on an ongoing basis in service utilization, costing, etc. Public CFSA's should be prepared to develop a system for providing "report cards" on the managed care entity (whether internal or with provider-based services) so that service costs, effectiveness, access and responsiveness can assist the Public CFSA in assessing service viability for children and their families.

**N. Monitoring Contract Compliance**

- 1) The Public CFSA should monitor its managed care contracts for compliance with the contract terms and conditions. To monitor compliance with service expectations, the Public CFSA should have procedures for internal controls which effectively monitor, maintain, and evaluate the administration and operation of the managed care system (see Standard 10.10, *Contract Development*).

**O. Outcome Measures and Performance Analysis**

Outcome measures are integral to managing effective systems of care. Managed care is a strategy used for maximizing resources, reducing inefficiencies, and assuring the provision of effective services.

- 1) Well-defined outcome measures provide the foundation from which the Public CFSA and MCE can measure the quality and level of delivered services. Data gathered as a result of articulated measures must be valid and reliable. If the outcomes and/or data generated from them are susceptible to interpretation, it will be difficult to reward and/or sanction providers participating in the managed care system.

**P. Managing Continuity of Care**

- 1) The Public CFSA should assure the optimal coordination of services, without disruption, throughout the life of the child and family case. Continuity of care should include:
  - a. provision of a single point of entry to care management at which to screen, determine eligibility based on service necessity criteria, assess clinical needs;
  - b. coordination of the assessment of the needs of the child and family served and monitoring and coordinating the delivery of necessary evaluations and assessments to verify the child and family's needs;
  - c. coordination of treatment planning and participation in same to assure inclusion of specific objectives, as well as an explanation of the availability, intensity and duration required of each service;
  - d. linking of the child and family with qualified, credentialed providers and services in the most timely manner possible;

- e. coordination of crisis intervention and stabilization;
- f. provision of training and facilitating linkages for the child and family in the use of basic community resources;
- g. review and monitoring of overall service delivery and activities, noting progress, providing authorization/reauthorization of services based on assessment, utilization, and appropriate care criteria;
- h. obtainment of any services necessary for meeting the child and family's basic human needs;
- i. maintenance of relevant documentation and provision of statistical reporting data.

## Q. Managing Cost of Care and Financial Risk

### Pricing & Risk

The Public CFSA must be able to manage the risk being placed upon it under a managed care approach. While risk can be placed at various levels within the service system or shared among different levels, it must be managed to ensure that resources are available for those requiring care.

The Public CFSA can choose various methods for developing its managed care environment including the use of capitated rates or flat fee per client rate. Both methods would assist the Public CFSA in costing services. However, the number of children to be served, and available funds, will determine which method is best.

Regardless of the pricing method used, the Public CFSA should develop protocols for identifying what services will be provided under managed care, who should receive these services and what the cost should be for providing those services.

The Public CFSA and MCE should have the ability to track and report costs by a variety of criteria; have a sound financial accounting system and internal controls; and meet federal or other audit requirements. Both the Public CFSA and MCE should have the capacity to maximize third party revenues.

### 1) Pricing

#### a. Capitation

Using capitation as a method for determining pricing, the Public CFSA would determine all of the services to be provided by the provider. These would be added together and divided by the entire population that could be served. The Public CFSA would then determine the percentage of the entire population that will likely receive services in relation to available funding. Under this system, a broad representation of individuals are covered, but not necessarily "sick" or in need of services.

For example, using capitation, the entire child population (under the age of 5 yrs.) of county x is 100,000 children, of this population of children, what percentage will require WIC assistance? The Public CFSA would divide available WIC resources into the total population and multiply that figure by the number of children likely to need WIC assistance.

#### b. Case Rate System

Using Case Rate as a method for determining pricing, the Public CFSA would define the specific population of children (abused, neglected) that would likely be served (based on past statistics, trends analysis, etc.). The Public CFSA would

also determine all costs associated with the client population identified. The population of clients would be divided into the total cost. The provider would be paid a flat fee per client, regardless of the duration of service and regardless of the actual cost per client. With this system, the duration of service provision must be clearly defined.

For example, the Public CFSA identifies that it has served approximately 100,000 children on an annual basis with a growth rate of 10% per year. Recognizing that some of these children will require more assistance than others, the CFSA determines the per case rate based on available funding and number of children to be served.

## 2) General Considerations for Pricing

To determine the pricing of services, the Public CFSA should consider using the following methodology:

- a. identify the population to be served;
- b. establish eligibility criteria (levels of care, physical/emotional problems, etc.);
- c. estimate the number of eligible (may require regionalizing for small counties);
- d. assess the population's characteristics and needs;
- e. establish program goals and desired child outcomes (outcomes must be clearly defined and must be used to form the basis for system development and service provision);
- f. identify service components which will achieve the desired outcomes and program goals;
- g. establish the cost of a unit of service;
- h. determine whether to purchase services through a case rate system;
- i. establish the number of service units and the number of children who will be placed in the case rate system;
- j. estimate the direct service costs by multiplying the number of units by the cost per unit by the number of case rate children and case rate cost;
- k. estimate the fixed service costs not included in the above (e.g., 24 hour emergency hotline, emergency staff, etc.);
- l. estimate administrative costs:
  - i. service center and operation costs,
  - ii. utilization management costs,
  - iii. provider network development and maintenance costs,
  - iv. quality assurance and appeals process,
  - v. management information system,
  - vi. financial management and claims processing,
  - vii. training and staff development,
  - viii. incentive and other fund pools,
  - ix. other administrative costs;
- m. determine the desired capitation rate: total annual services costs, plus administrative costs, divided by the number of eligible. Divide the desired rate by 12 months by the number of eligible. This should provide the per eligible per month rate;
- n. identify all fund sources available to the managed care initiative;
- o. divide available resources by the number of eligible projected in
- p. compare the available capitation rate with the desired rate and adjust if necessary (e.g., increase in available funds, decrease in the number of those eligible, decrease in goal and service expectations);

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- q. Public CFSA staff should review the following managed care documents when considering the viability of managed care for the organization:
    - i. Managed Care (Unraveling The Mysteries) A Resource Manual: Columbus, Ohio 9/95, Child Welfare League Of America, Washington D.C;
    - ii. Managed Care Initiative Design, Ohio Department Of Human Services: Office Of Child Care And Family Services, Columbus, Ohio: prepared by The Technical Assistance Collaborative, 7/95.
- 3) Risk
- To manage financial risk, the Public CFSA and providers within the managed care system must have access to client utilization and cost data. There must also be an ability to negotiate and set rates with providers and selectively contract with providers, based on indicators of performance and cost effectiveness. Finally, the Public CFSA must have adequate financial resources to cover unforeseen service needs as they arise.
- a. Non-Risk Based Contracts  
The Public CFSA and MCE may negotiate a non-risk based contract. Under this condition, the provider is not at financial risk for changes in the cost of utilization of services provided. The Public CFSA may retroactively adjust the payment rate during the contract period, or reconcile payments to costs at the end of the contract period, so the contractor is reimbursed for actual costs incurred.
  - b. Risk-Based Contracts  
The Public CFSA and MCE may negotiate for a shared risk-based contract. Under this condition, the provider would be at-risk of loss if the cost of providing services exceeds the payments made for those services. The Public CFSA would be at-risk of loss if the cost of providing services are less than payments made.

## V. Financial Implications

Costs associated with managing services to children and families through quality assurance activities and cost containment mechanisms are assumed to be balanced by the costs savings or containment of costs.